FEMA/OER Post World Trade Center Response Medical Questionnaire

The following information is being collected along with your medical examination and laboratory studies. Your answers to these questions will help us to determine the nature and level of your possible exposures and the significance of any symptoms you may have. Please take the time to answer the questionnaire completely. Questions on symptoms, in section 4, are answered using the key provided immediately above that section. This survey is for personnel who were deployed to NYC in response to the WTC disaster anytime from 9/11/01 through 6/30/02.

Please Print

Name:	Sex: ___ M ___ F	Date of Birth: / / (MM/DD/YYYY)
Home Address:	SSN:	
	Home Phone:	
	Work Phone:	
	Email Address:	

1. **Job Description***

a. Job at WTC:	b. WTC Supervisor:
c. WTC Unit Assignment:	d. Dates deployed From: To:
e. WTC Unit Type: ❑ DMAT ❑ DMORT ❑ CCRF ❑ MST ❑ NMRT ❑ DMHT ❑ VMAT ❑ USAR ❑ ERT ❑ EIS ❑ CLRT ❑ PA ❑ CD ❑ IA ❑ DEST ❑ HAZMAT ❑ OTHER:	
f. Work included: (check all that apply) ❑ Urban search and rescue ❑ MERS ❑ Community relations / public assistance ❑ Inspection services ❑ Medical services / surveillance ❑ Mortuary services ❑ Operations / administration ❑ Safety and security ❑ Logistics / TLC ❑ Mitigation ❑ Congressional affairs ❑ Individual assistance (non-medical) ❑ Other (specify): _____	

*If you deployed more than once or were assigned to more that one unit or job, provide additional details on the last page, under section 5. Please enter information for the job that consumed the largest portion of your total time in this section.

2. **Exposure History**

a. Which of the following best describes your worst exposure to dust if you were in lower Manhattan at any time on 9/11/01? Would you say you were:
- ❑ Not in lower Manhattan on 9/11 or I was not exposed to dust from the collapse of the WTC buildings.
- ❑ Directly in the cloud of dust (or "blackout") from the collapse of the World Trade Center buildings.
- ❑ Exposed to significant amounts of dust but not directly in the cloud of dust from the collapse of the WTC.
- ❑ Exposed to some dust but not directly in the cloud of dust from the collapse of the WTC buildings.
- ❑ In lower Manhattan on 9/11, but I don't know how much dust I was exposed to.

	September 2001†	October 2001†	November – December 2001†	January – June 2002†
b. Did you participate in WTC rescue, recovery, debris clean-up or related support services at anytime during this time period?	❑ YES ❑ NO ❑ Don't know	❑ YES ❑ NO ❑ Don't know	❑ YES ❑ NO ❑ Don't know	❑ YES ❑ NO ❑ Don't know
c. How many days did you work during this period?	_____	_____	_____	_____
d. What was the average number of hours that you worked per day during this period?	_____	_____	_____	_____
e. Did you work primarily on the day or night shifts, or both?	❑ Day ❑ Night ❑ Both ❑ N/A ❑ Don't know	❑ Day ❑ Night ❑ Both ❑ N/A ❑ Don't know	❑ Day ❑ Night ❑ Both ❑ N/A ❑ Don't know	❑ Day ❑ Night ❑ Both ❑ N/A ❑ Don't know

†If your answer to question 2b is "no" for any time period (column) leave the rest of that column below question 2b blank, throughout section 2 on the next two pages.

	September 2001	October 2001	November – December 2001	January – June 2002
f. During the period, where did you spend the majority of your shifts? (If you were not deployed during the period, check "Elsewhere (n/a)") (OCME= Office of the Coroner and Medical Examiner)	❑ On the pile/in the pit ❑ Adjacent to pile/pit (damage zone) ❑ Elsewhere south of Canal St. ❑ At the landfill ❑ At barges/ loading piers ❑ OCME ❑ Elsewhere (n/a) ❑ Don't know	❑ On the pile/in the pit ❑ Adjacent to pile/pit (damage zone) ❑ Elsewhere south of Canal St. ❑ At the landfill ❑ At barges/ loading piers ❑ OCME ❑ Elsewhere (n/a) ❑ Don't know	❑ On the pile/in the pit ❑ Adjacent to pile/pit (damage zone) ❑ Elsewhere south of Canal St. ❑ At the landfill ❑ At barges/ loading piers ❑ OCME ❑ Elsewhere (n/a) ❑ Don't know	❑ On the pile/in the pit ❑ Adjacent to pile/pit (damage zone) ❑ Elsewhere south of Canal St. ❑ At the landfill ❑ At barges/ loading piers ❑ OCME ❑ Elsewhere (n/a) ❑ Don't know
g. During the period, did you do any enclosed space entry (i.e., into tunnels, tanks, basements, etc.)?	❑ Yes ❑ No ❑ N/A ❑ Don't know	❑ Yes ❑ No ❑ N/A ❑ Don't know	❑ Yes ❑ No ❑ N/A ❑ Don't know	❑ Yes ❑ No ❑ N/A ❑ Don't know
h. Did you do yourself or did you work in the immediate area of anyone who was cutting, breaking-up, or drilling concrete?	❑ Yes ❑ No ❑ N/A ❑ Don't know	❑ Yes ❑ No ❑ N/A ❑ Don't know	❑ Yes ❑ No ❑ N/A ❑ Don't know	❑ Yes ❑ No ❑ N/A ❑ Don't know
i. Did you do yourself or did you work in the immediate area of anyone who was using a welding torch to cut or burn materials?	❑ Yes ❑ No ❑ N/A ❑ Don't know	❑ Yes ❑ No ❑ N/A ❑ Don't know	❑ Yes ❑ No ❑ N/A ❑ Don't know	❑ Yes ❑ No ❑ N/A ❑ Don't know
j. While doing WTC recovery work, did you come in direct contact with any of these specific hazards at any time during the period? (Place check in the box by each hazard contacted, otherwise leave blank; if "other" then specify.)	❑ Human remains ❑ Blood/bodily fluids ❑ Dust ❑ Mold ❑ Chemical liquids ❑ Welding fumes ❑ Sewage ❑ Smoke from fires ❑ Diesel exhaust ❑ Other exhaust ❑ Repetitive motion work ❑ Heavy vibration (jackhammer) ❑ Lifting $\leq$30# ❑ Lifting >30# ❑ Heat (air >80^{o}F) ❑ Cold (air <32^{o}F) ❑ Loud noise ❑ Other ____________	❑ Human remains ❑ Blood/bodily fluids ❑ Dust ❑ Mold ❑ Chemical liquids ❑ Welding fumes ❑ Sewage ❑ Smoke from fires ❑ Diesel exhaust ❑ Other exhaust ❑ Repetitive motion work ❑ Heavy vibration (jackhammer) ❑ Lifting $\leq$30# ❑ Lifting >30# ❑ Heat (air >80^{o}F) ❑ Cold (air <32^{o}F) ❑ Loud noise ❑ Other ____________	❑ Human remains ❑ Blood/bodily fluids ❑ Dust ❑ Mold ❑ Chemical liquids ❑ Welding fumes ❑ Sewage ❑ Smoke from fires ❑ Diesel exhaust ❑ Other exhaust ❑ Repetitive motion work ❑ Heavy vibration (jackhammer) ❑ Lifting $\leq$30# ❑ Lifting >30# ❑ Heat (air >80^{o}F) ❑ Cold (air <32^{o}F) ❑ Loud noise ❑ Other ____________	❑ Human remains ❑ Blood/bodily fluids ❑ Dust ❑ Mold ❑ Chemical liquids ❑ Welding fumes ❑ Sewage ❑ Smoke from fires ❑ Diesel exhaust ❑ Other exhaust ❑ Repetitive motion work ❑ Heavy vibration (jackhammer) ❑ Lifting $\leq$30# ❑ Lifting >30# ❑ Heat (air >80^{o}F) ❑ Cold (air <32^{o}F) ❑ Loud noise ❑ Other ____________
k. During this period, how often would you wash your hands before eating or drinking at the job site?	❑ Always ❑ Often ❑ Sometimes ❑ Never ❑ Don't know	❑ Always ❑ Often ❑ Sometimes ❑ Never ❑ Don't know	❑ Always ❑ Often ❑ Sometimes ❑ Never ❑ Don't know	❑ Always ❑ Often ❑ Sometimes ❑ Never ❑ Don't know

	September 2001	October 2001	November – December 2001	January – June 2002
l. During this period, how often did you change out of your work clothes before leaving the worksite?	❑ Always ❑ Often ❑ Sometimes ❑ Never ❑ Don't know	❑ Always ❑ Often ❑ Sometimes ❑ Never ❑ Don't know	❑ Always ❑ Often ❑ Sometimes ❑ Never ❑ Don't know	❑ Always ❑ Often ❑ Sometimes ❑ Never ❑ Don't know
m. During this period, how often did you take a shower before leaving the worksite?	❑ Always ❑ Often ❑ Sometimes ❑ Never ❑ Don't know	❑ Always ❑ Often ❑ Sometimes ❑ Never ❑ Don't know	❑ Always ❑ Often ❑ Sometimes ❑ Never ❑ Don't know	❑ Always ❑ Often ❑ Sometimes ❑ Never ❑ Don't know
n. Where did you sleep during the period? (On-site = your worksite, not necessarily ground zero.)	❑ Always off-site ❑ Usually off-site but sometimes on-site ❑ Usually on-site but sometimes off-site ❑ Always on-site ❑ Don't know	❑ Always off-site ❑ Usually off-site but sometimes on-site ❑ Usually on-site but sometimes off-site ❑ Always on-site ❑ Don't know	❑ Always off-site ❑ Usually off-site but sometimes on-site ❑ Usually on-site but sometimes off-site ❑ Always on-site ❑ Don't know	❑ Always off-site ❑ Usually off-site but sometimes on-site ❑ Usually on-site but sometimes off-site ❑ Always on-site ❑ Don't know

3. **Personal Protective Equipment Use**

	Percentage of on-the-job time each item was used					
The following personal protective equipment was used† (Please check all that apply)	Not used	1-25%	26-50%	51-75%	76-95%	95-100%
a. No equipment used						
b. Coveralls (Tyvek, Posi-wear, etc.)						
c. Eye protection (goggles, face shield, safety glasses)						
d. Respiratory protection Dust mask						
Half-face respirator (mask)						
Full-face respirator (mask)						
SCBA or air line						
e. Steel-toed construction shoes						
f. Gloves (specify type):						
g. Hearing protection (ear plugs, muffs)						
h. Other (specify):						

i. Did you use your items of personal protective equipment every time that you should have, that is, whenever you were exposed to the hazards that the equipment protected against?	❑ Always ❑ Sometimes ❑ Often ❑ Never ❑ Don't know
j. Did you at any time (prior to or during the WTC response) receive training on how to use each of the personal protective equipment items made available to you during the WTC disaster response?	❑ I was trained on the use of ALL of my equipment ❑ I was trained on the use of SOME of my equipment ❑ I had no specific training at all
k. If you wore a half- or full-face respirator (including SCBA), were you ever fit-tested prior to the respirator being issued and worn?	❑ Yes ❑ No ❑ I did not wear a respirator

†If no personal protective equipment was used at all, mark the 95-100% box on line 2a and proceed to next section. Otherwise, mark the approximate percentage of time none was used and then mark the appropriate additional responses on the lines below. For example, if no equipment was used ~40% of the time, a dusk mask was worn ~10% of the time, a half-face respirator ~30%, and ear plugs ~70%, then mark the 26-50% box on line 2a, the 1-25% box for dust mask on line 2d, the 25-50% box for half-face respirator on line 2d, and the 51-25% box for hearing protection on line 2g. Items need NOT total 100%.

Use the key below to complete your more detailed responses for 'Yes' answers for section 4.

1. WHEN did you FIRST experience this symptom or condition?
   [When first? = (P) Prior to the WTC work, (W) While there, (A) After]
2. Is this a NEW symptom or condition?
   [New? = (Y) Yes or (N) No]
3. Or is this a WORSEning of a symptom or condition you had *prior* to the WTC work?
   [Worse? = (Y) Yes or (N) No]
4. How would you rate the SEVERITY of this symptom or condition on a scale of 1 to 10?
   [Severity? = 1 (very mild) to 10 (very severe)]
5. How FREQUENTLY you experience this symptom or condition?
   [Frequency? = (D) every day, (W) at least once a week, (M) at least once a month, (L) less]
6. Have you sought medical CARE regarding this symptom or condition?
   [Care? = (N) No or (Y) Yes]
   a. If so, did you receive a Diagnosis? [Dx? = (Y) Yes or (N) No]
   b. Were you given any Treatment? [Tx? = (Y) Yes or (N) No]
7. Do you think it was caused by a WTC exposure? [WTC = (Y) Yes or (N) No]

4. **While or since working at the World Trade Center disaster site, did you experience any of the following of the following symptoms or conditions?** (Please check the "yes" or "no" box for each system and if "yes", circle the appropriate letter under each question to the right and numerically rank the severity of the complaint. Note there are 2 rows of responses for each yes answer.)

a.	Persistent tearing, crusting, or dry eyes ❑YES ❑NO	**IF YES →** ↘	When first? P W A	New? Y N	Worse? Y N	Severity? 1-10: ____
		Frequency? D W M L	Medical care? Y N	Dx? Y N	Tx? Y N	WTC? Y N
b.	Headaches ❑YES ❑NO	**IF YES →** ↘	When first? P W A	New? Y N	Worse? Y N	Severity? 1-10: ____
		Frequency? D W M L	Medical care? Y N	Dx? Y N	Tx? Y N	WTC? Y N
c.	Dizziness ❑YES ❑NO	**IF YES →** ↘	When first? P W A	New? Y N	Worse? Y N	Severity? 1-10: ____
		Frequency? D W M L	Medical care? Y N	Dx? Y N	Tx? Y N	WTC? Y N
d.	Nasal discharge, nose bleeds, odors (other than colds) ❑YES ❑NO	**IF YES →** ↘	When first? P W A	New? Y N	Worse? Y N	Severity? 1-10: ____
		Frequency? D W M L	Medical care? Y N	Dx? Y N	Tx? Y N	WTC? Y N
e.	Irritation of nose or sinuses (other than colds) ❑YES ❑NO	**IF YES →** ↘	When first? P W A	New? Y N	Worse? Y N	Severity? 1-10: ____
		Frequency? D W M L	Medical care? Y N	Dx? Y N	Tx? Y N	WTC? Y N
f.	Asthma or reactive airway disease ❑YES ❑NO	**IF YES →** ↘	When first? P W A	New? Y N	Worse? Y N	Severity? 1-10: ____
		Frequency? D W M L	Medical care? Y N	Dx? Y N	Tx? Y N	WTC? Y N
g.	Bronchitis ❑YES ❑NO	**IF YES →** ↘	When first? P W A	New? Y N	Worse? Y N	Severity? 1-10: ____
		Frequency? D W M L	Medical care? Y N	Dx? Y N	Tx? Y N	WTC? Y N
h.	Persistent cough ❑YES ❑NO	**IF YES →** ↘	When first? P W A	New? Y N	Worse? Y N	Severity? 1-10: ____
		Frequency? D W M L	Medical care? Y N	Dx? Y N	Tx? Y N	WTC? Y N

l.	Wheezing or shortness of breath ❑YES ❑NO	**IF YES →** ↘ Frequency? D W M L	When first? P W A Medical care? Y N	New? Y N Dx? Y N	Worse? Y N Tx? Y N	Severity? 1-10: ____ WTC? Y N
j.	Other respiratory tract illness (cold, flu, laryngitis) ❑YES ❑NO	**IF YES →** ↘ Frequency? D W M L	When first? P W A Medical care? Y N	New? Y N Dx? Y N	Worse? Y N Tx? Y N	Severity? 1-10: ____ WTC? Y N
k.	Chest tightness ❑YES ❑NO	**IF YES →** ↘ Frequency? D W M L	When first? P W A Medical care? Y N	New? Y N Dx? Y N	Worse? Y N Tx? Y N	Severity? 1-10: ____ WTC? Y N
l.	Chest pain ❑YES ❑NO	**IF YES →** ↘ Frequency? D W M L	When first? P W A Medical care? Y N	New? Y N Dx? Y N	Worse? Y N Tx? Y N	Severity? 1-10: ____ WTC? Y N
m.	Heartburn or acid indigestion ❑YES ❑NO	**IF YES →** ↘ Frequency? D W M L	When first? P W A Medical care? Y N	New? Y N Dx? Y N	Worse? Y N Tx? Y N	Severity? 1-10: ____ WTC? Y N
n.	Heat injury (heat stroke or exhaustion) ❑YES ❑NO	**IF YES →** ↘ Frequency? D W M L	When first? P W A Medical care? Y N	New? Y N Dx? Y N	Worse? Y N Tx? Y N	Severity? 1-10: ____ WTC? Y N
o.	Closed wound injury (fracture, bruise, crush) ❑YES ❑NO	**IF YES →** ↘ Frequency? D W M L	When first? P W A Medical care? Y N	New? Y N Dx? Y N	Worse? Y N Tx? Y N	Severity? 1-10: ____ WTC? Y N
p.	Open wound injury (laceration, puncture, compound fracture) ❑YES ❑NO	**IF YES →** ↘ Frequency? D W M L	When first? P W A Medical care? Y N	New? Y N Dx? Y N	Worse? Y N Tx? Y N	Severity? 1-10: ____ WTC? Y N
q.	Burn injury (other than mild sunburn) ❑YES ❑NO	**IF YES →** ↘ Frequency? D W M L	When first? P W A Medical care? Y N	New? Y N Dx? Y N	Worse? Y N Tx? Y N	Severity? 1-10: ____ WTC? Y N
r.	Persistent rash, hives, itching ❑YES ❑NO	**IF YES →** ↘ Frequency? D W M L	When first? P W A Medical care? Y N	New? Y N Dx? Y N	Worse? Y N Tx? Y N	Severity? 1-10: ____ WTC? Y N
s.	Muscle strain or sprain ❑YES ❑NO	**IF YES →** ↘ Frequency? D W M L	When first? P W A Medical care? Y N	New? Y N Dx? Y N	Worse? Y N Tx? Y N	Severity? 1-10: ____ WTC? Y N
t.	Breathing trouble when wearing respiratory equipment ❑YES ❑NO	**IF YES →** ↘ Frequency? D W M L	When first? P W A Medical care? Y N	New? Y N Dx? Y N	Worse? Y N Tx? Y N	Severity? 1-10: ____ WTC? Y N
u.	Restlessness, sleeplessness, or nightmares ❑YES ❑NO	**IF YES →** ↘ Frequency? D W M L	When first? P W A Medical care? Y N	New? Y N Dx? Y N	Worse? Y N Tx? Y N	Severity? 1-10: ____ WTC? Y N
v.	Difficulty concentrating, obsessive thoughts, intrusive thoughts ❑YES ❑NO	**IF YES →** ↘ Frequency? D W M L	When first? P W A Medical care? Y N	New? Y N Dx? Y N	Worse? Y N Tx? Y N	Severity? 1-10: ____ WTC? Y N

w.	Intense anger, emotional outbursts, withdrawal ❑YES ❑NO	**IF YES →** ↘	When first? P W A	New? Y N	Worse? Y N	Severity? 1-10: ____
		Frequency? D W M L	Medical care? Y N	Dx? Y N	Tx? Y N	WTC? Y N
x.	Increased alcohol or drug use (illegal or non-prescribed) ❑YES ❑NO	**IF YES →** ↘	When first? P W A	New? Y N	Worse? Y N	Severity? 1-10: ____
		Frequency? D W M L	Medical care? Y N	Dx? Y N	Tx? Y N	WTC? Y N
y.	Change in emotional status (depression, anxiety, worry, fear) ❑YES ❑NO	**IF YES →** ↘	When first? P W A	New? Y N	Worse? Y N	Severity? 1-10: ____
		Frequency? D W M L	Medical care? Y N	Dx? Y N	Tx? Y N	WTC? Y N
z.	Other (specify) ❑YES ❑NO	**IF YES →** ↘	When first? P W A	New? Y N	Worse? Y N	Severity? 1-10: ____
		Frequency? D W M L	Medical care? Y N	Dx? Y N	Tx? Y N	WTC? Y N
aa.	Other (specify) ❑YES ❑NO	**IF YES →** ↘	When first? P W A	New? Y N	Worse? Y N	Severity? 1-10: ____
		Frequency? D W M L	Medical care? Y N	Dx? Y N	Tx? Y N	WTC? Y N

5. **Any additional comments on above responses should be added below. Please identify the letter of the question (1a to 4aa).** If additional space is needed, attach another paper with the information.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Privacy Act Statement

The collection and use of this information is authorized by 5 U.S.C. 7901 (Health Service Programs) and 29 U.S.C. 657 (Occupational Health and Safety; Record Keeping). The information will become part of your official Employee Medical File, and will be used to assist Federal Occupational Health in carrying out its occupational health services responsibilities under one or more interagency agreements with your employing agency, and for other official purposes and routine uses as described in Privacy Act systems notice OPM/GOVT-10 (Employee Medical File System Records). Providing the requested information is voluntary. Not providing the information may affect the availability and quality of health services rendered to you, and may also affect the completeness of information used by your agency in making determinations of medically-related employment decisions.